MEDICAID

MONTANA MEDICAID CERTIFICATE OF MEDICAL NECESSITY

DURABLE MEDICAL EQUIPMENT AND SUPPLIES (Rev., Jul 99)

PARENTERAL THERAPY

PATIENT NAME, ADDRESS, TELEPHONE NUMBER, DATE OF BIRTH	PHYSICIAN NAME, ADDRESS, TELEPHONE NUMBER
MEDICAID I.D. NUMBER:	MEDICAID PROVIDER NUMBER:

DIAGNOSIS: HEIGHT: WEIGHT:

PROGNOSIS: EST. LENGTH OF NEED (# OF MONTHS): 1-99 (99 = LIFETIME)

1. Description of Functional Impairment

___ Malabsorpion
___ Non-functioning GI Tract
___ Mental Incapacity
___ Hyper metabolic
___ Aspiration
___ Swallowing Impairment
___ Intestinal Obstruction
___ Nausea/Vomiting
___ Impaired Consciousness
___ Other _____

2. Formula components:

Amino Acid _____(ml/day) _____ concentration % _____ gms protein/day

Dextrose _____ (ml/day) _____concentration %

Lipids _____ (ml/day) _____ days/week _____ concentration %

3. Current residence: (circle the appropriate) Home, Nursing Home, Hospital Rehab Unit, Institution, Group Home, Other _____

4. Does the patient have severe permanent disease of the gastrointestinal tract causing Malabsorpion severe enough to prevent maintenance of weight and strength commensurate with the patient's overall health status? Y / N

5. How many days per week is the patient infused? (Enter 1-7)

6. Circle the route of administration: Central Line; Hemodialysis Access Line; Peripherally Inserted Catheter (PIC)

7. Narrative description of **ALL** items, accessories, options and special additives ordered to include supply changes and amounts: (If additional space is needed, a continued narrative can be attached to this document as long as the pertinent patient and physician information is included at the top of the attachment. Physician's signature must also be included on the attached document.)

Y / N ADDITIONAL ATTACHMENTS ARE INCLUDED

I certify that I am the treating physician identified in this form. I certify that the medical necessity information contained in this document and its attachments are true, accurate and complete, to the best of my knowledge, and I understand that any falsification, omission, or concealment of material fact in this document may subject me to civil or criminal liability.

PHYSICIAN'S SIGNATURE _____ DATE ____/____/____ (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)

MONTANA
Department of Public Health & Human Services